I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree and consent to participate in

(Name of Client and DOB)

behavioral health care services offered and provided by Ali Waltien, MA. I understand that the provider is a licensed clinical psychologist, master’s level. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider’s certification and training. I understand that my participation in treatment is voluntary and I may choose to terminate treatment at any time.

*For Services to Children:*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as the legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Legal Guardian Name of Child and DOB

agree to allow Ali Waltien, MA to provide counseling services to my child. I understand that the provider is a licensed clinical psychologist, master’s level. I attest that I have legal custody of the individual receiving treatment and am authorized to initiate and consent for treatment on behalf of this individual. I will respect the confidentiality between the therapist and my child in order to bring about more effective treatment. In the event I do wish to obtain more information about my child’s treatment, I will schedule an appointment. I understand that the participation of my child in treatment is voluntary and I may terminate the treatment at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Client Signature Print Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Parent/Guardian Signature Print Name Date